



Virginia
Regulatory
Town Hall

Final Regulation Agency Background Document

Agency Name:	Virginia Department of Health
VAC Chapter Number:	12 VAC 5-408-10
Regulation Title:	Certificate of Quality Assurance of Managed Care Health Insurance Plan Licensees
Action Title:	Adopt amendments to above regulation
Date:	November 9, 2001

Please refer to the Administrative Process Act (§ 9-6.14:9.1 *et seq.* of the *Code of Virginia*), Executive Order Twenty-Five (98), Executive Order Fifty-Eight (99) , and the *Virginia Register Form, Style and Procedure Manual* for more information and other materials required to be submitted in the final regulatory action package.

Summary

Please provide a brief summary of the new regulation, amendments to an existing regulation, or the regulation being repealed. There is no need to state each provision or amendment; instead give a summary of the regulatory action. If applicable, generally describe the existing regulation. Do not restate the regulation or the purpose and intent of the regulation in the summary. Rather, alert the reader to all substantive matters or changes contained in the proposed new regulation, amendments to an existing regulation, or the regulation being repealed. Please briefly and generally summarize any substantive changes made since the proposed action was published.

The amendments to the regulation reflect the Department of Health's ("Department") enhanced understanding of the inherent differences within managed care insurance plan licensees. In order to promulgate a reasonable regulation, the Department sought to accommodate these differences. Rather than regulate managed care health insurance plan ("MCHIP") licensees in a homogenous manner, as does the extant regulation, the amendments ensure the regulation (a) makes appropriate distinctions between preferred provider organizations ("PPOs") and health maintenance organizations ("HMOs"); (b) limits compliance in sections requiring clinical data to those MCHIP licensees that have access to clinical data; (c) allows PPOs that do not have clinical data to demonstrate quality assurance in administering care rather than delivering care; and (d) provides greater opportunities for voluntary compliance by eliminating unnecessarily prescriptive language.

Changes Made Since the Proposed Stage

Please detail any changes, other than strictly editorial changes, made to the text of the proposed regulation since its publication. Please provide citations of the sections of the proposed regulation that have been altered since the proposed stage and a statement of the purpose of each change.

There are only three substantive changes that the Department proposes to make to the regulation in response to the comments received. The first is to amend 12 VAC 5-408-170 concerning credentialing. A new item number six shall be placed after 12 VAC 5-408-170 D.5. The purpose of this change is to ensure timely processing of credentialing information. The Department proposes that the new language read as follows:

6. A requirement that the MCHIP licensee notify the applicant within 60 calendar days of receipt of an application if information is missing or if there are other deficiencies in the application. The MCHIP licensee shall complete the credentialing process within 90 calendar days of the receipt of all such information requested by the MCHIP licensee or, if information is not requested from the applicant, within 120 calendar days of receipt of an application. The Department may impose administrative sanctions upon an MCHIP licensee for failure to complete the credentialing process as provided herein if it finds that such failure occurs with such frequency as to indicate a general business practice.

Immediately following the above amended language will be proposed language that will be numbered item 7. It provides for administrative simplification to likewise accelerate the credentialing process. The language is proposed to read as follows:

7. A provider fully credentialed by an MCHIP licensee, who changes his place of employment or his non-MCHIP licensee employer, shall, if within 60 calendar days of such change and if practicing within the same specialty, continue to be credentialed by that MCHIP licensee upon receipt by the MCHIP licensee of the following:

- a. The effective date of the change;
- b. The new tax ID number and copy of W-9, as applicable;
- c. The name of the new practice, contact person, address, telephone number and fax number; and
- d. Other such information as may materially differ from the most recently completed credentialing application submitted by the provider to the MCHIP.

This provision shall not apply if the provider's prior place of employment or employer had been delegated credentialing responsibility by the MCHIP licensee.

This subsection will conclude with a final sentence numbered 8.

8. Nothing in this section shall be construed to require an MCHIP licensee to contract or re-contract with a provider.

The final change proposed by the Department in response to the comments received is to clarify the language currently found at 12 VAC 5-408-360 C. A misplaced and vague phrase may be interpreted to limit recognition of a nationally recognized accrediting body to a particular accreditation or certification program. To correct the vague language, subsection C is proposed to be amended to read, "The MCHIP licensee, or its contracted private review agent or other delegated service entity for utilization review and management services, may demonstrate compliance with the utilization management and review requirements of this section by attaining accreditation or certification with the American Accreditation HealthCare Commission/URAC, the National Committee for Quality Assurance, or other nationally recognized accrediting body with comparable standards for utilization review or management accepted by the Department.

The proposed revision does not change the intent of the proposed regulation.

Statement of Final Agency Action

Please provide a statement of the final action taken by the agency: including the date the action was taken, the name of the agency taking the action, and the title of the regulation.

On December 7, 2001, the State Board of Health ("Board") pursuant to Section 32.1-20 of the Code of Virginia and in accordance with the bylaws of the Board, adopted the Rules and Regulations for Certification of Quality Assurance for Managed Care Health Insurance Plan Licensees, 12 VAC 5-408-10 et. seq. as a final agency regulation.

Basis

Please identify the state and/or federal source of legal authority to promulgate the regulation. The discussion of this statutory authority should: 1) describe its scope and the extent to which it is mandatory or discretionary; and 2) include a brief statement relating the content of the statutory authority to the specific regulation. In addition, where applicable, please describe the extent to which proposed changes exceed federal minimum requirements. Full citations of legal authority and, if available, web site addresses for locating the text of the cited authority, shall be provided. If the final text differs from that of the proposed, please state that the Office of the Attorney General has certified that the agency has the statutory authority to promulgate the final regulation and that it comports with applicable state and/or federal law.

The source of legal authority to promulgate the regulation is found at section 32.1-137.3 of the Code of Virginia. The Department of Health ("Department") understands that the authority to amend the regulation is derived from its authority to promulgate the regulation. The statute states, in relevant part: "Consistent with its duties to protect the health, safety, and welfare of the public, the Board [of Health] shall promulgate regulations, . . . governing the quality of care provided to covered persons by a managed care health insurance plan licensee through its managed care health insurance plans" Thus, the promulgation of the regulation was mandated by statute.

The statute may be viewed on the General Assembly Legislative Information System website at <http://leg1.state.va.us/lis.htm>.

Purpose

Please provide a statement explaining the need for the new or amended regulation. This statement must include the rationale or justification of the final regulatory action and detail the specific reasons it is essential to protect the health, safety or welfare of citizens. A statement of a general nature is not acceptable, particular rationales must be explicitly discussed. Please include a discussion of the goals of the proposal and the problems the proposal is intended to solve.

The current regulation assures MCHIP licensees have in place and comply with the quality systems procedures outlined in section 32.1-137.2 of Code of Virginia. Because there is an expanding number of persons enrolled in managed care health insurance plans, the aforementioned statute and regulation are essential to protect the health, safety and welfare of Virginia residents.

A number of MCHIP licensees expressed concern with the regulation because it: (a) did not provide notice of the Department's expectations and reasonable people had to guess at its meaning; (b) was internally inconsistent; (c) assumed organizational structures and capabilities for some MCHIP licensees that did not exist; and (d) was unreasonably prescriptive. The extant regulation contains language that permits the applicant to determine whether compliance with a particular section is appropriate given its organizational structure or capability. It does not offer guidance regarding the Department's expectations.

The proposed regulation seeks to maximize compliance by providing a regulation that is clearly written. It identifies specific sections with which certain MCHIP licensees need not comply. It offers examples of acceptable activities for compliance. Finally, it permits the Department greater flexibility in allowing for variances provided patient care, safety, or the ability of an MCHIP licensee to provide or arrange for care will not be adversely affected.

Substance

Please identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. Please note that a more detailed discussion is required under the statement of the regulatory action's detail.

The Department proposes to amend the regulation where necessary, including, but not limited to: (a) providing criteria to permit the granting of variances by the Department; (b) clarifying the exemptions regarding PPOs to better address unique aspects of this type of managed care health insurance plan; (c) providing a more clear distinction between the MCHIP and MCHIP licensees; and (d) eliminating internal inconsistencies regarding PPO responsibilities.

Issues

Please provide a statement identifying the issues associated with the final regulatory action. The term "issues" means: 1) the advantages and disadvantages to the public of implementing the new provisions; 2) the advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, please include a sentence to that effect.

There are no perceived disadvantages to the public or to the Commonwealth associated with the proposed regulatory action. The advantages of amending the MCHIP regulation are many.

The greatest advantage is that Virginia citizens enrolled in MCHIPs will be the beneficiaries of a regulation that assures these plans have appropriate standards for ensuring quality. The extant regulation, while detailed, does not contemplate the great variation in MCHIP organizational structures or abilities. Thus, while the regulation may have appropriate criteria for HMOs, PPOs may find compliance difficult. This difficulty may result in additional costs to PPOs that may be passed along to enrollees or to businesses in the form of higher premiums. Because the criteria are not appropriate for PPOs, their compliance efforts do not necessarily result in enhanced quality. The proposed regulations promote meaningful quality activities.

There is also a great advantage to the Department in amending the regulation. Its ability to maintain effective regulatory programs during a period characterized by increasingly complex and dynamic health care change will be strengthened. The Department has worked hard in getting input from many stakeholders in the amendment process. It has convened an advisory committee comprised of members of the regulated industry, consumers, advocates and purchasers. The amendments represent a consensus by these groups and the good faith effort by the Department to incorporate language evidencing consensus when possible. Thus, it is not only the substance of the proposed amended regulation that represents an improvement, but the process of involving stakeholders in the regulatory process in a meaningful manner is likewise an improvement.

Finally, the regulation provides further evidence of the Governor's commitment to create a "level playing field" between HMOs and PPOs. The current regulation interprets that commitment to mean HMOs and PPOs must be treated the same. Thus, it subjects PPOs to a regulation appropriate to HMOs, yet burdensome for PPOs given their organizational structure. The result is that PPOs are placed at a distinct disadvantage, thereby precluding the possibility of a true "level playing field." The proposed regulation recognizes these inherent difficulties within the MCHIPs and encourages meaningful compliance by detailing a range of compliance possibilities and exempting PPOs when appropriate.

Public Comment

Please summarize all public comment received during the public comment period and provide the agency response. If no public comment was received, please include a statement indicating that fact.

The State Board of Health received nine comments during the public comment period that commenced on September 10, 2001 and ended on November 9, 2001. The majority of letters began by complimenting the Department for its participatory approach during the regulatory process. As the Virginia Association of Health Plan's ("VAHP") letter states, "VAHP has appreciated the opportunity to be involved in the process of revising the regulations. We have been pleased with the open and positive nature of our collaboration with the Virginia Department of Health and other stakeholders in this process. We commend the Health Department on their responsiveness to our concerns, and in their work to ensure that these regulations are enforceable in a manner that is both effective and fair." While the Department appreciates the many compliments, the following summary of public comments will only address those comments that suggest a change or state a concern.

One commenter's observations were entirely technical in nature and for that reason will not be discussed here. The comments of the other eight are reflected below:

Summary of Public Comment:	Agency Response:
<p>First Commenter:</p> <ul style="list-style-type: none"> * The definition of appeal should not include reconsideration of a "final adverse action" because it occurs within the external review processes of the Bureau of Insurance. * The regulation requires an MCHIP licensee's application to include a provider directory. Requesting this directory is a responsibility of the Bureau of Insurance. * Two associations suggest language be placed in the regulation that requires "the MCHIP to notify the applicant within 60 calendar days of receipt of an application if information is missing or if there are other deficiencies in the application. The MCHIP shall complete the credentialing process within 90 calendar days of the receipt of 	<p>The definition of appeal is not venue specific. The Department believes the definition must provide notice to the regulated industry as well as to consumers concerning what can be appealed. Because final adverse actions may be appealed, it should remain within the definition.</p> <p>The Department needs a copy of the provider directory to determine, among other quality issues, whether there are an adequate number of providers in a geographic area. While it is true the directory is requested by the Bureau of Insurance, this fact does not preclude the Department from likewise requesting a copy.</p> <p>The Department commends the two associations that worked diligently to draft the proposed language. One represents health plans and the other represents providers. The Department understands that quality concerns may result if providers are not timely credentialed and believes that, absent extenuating circumstances, 120 calendar days is a reasonable amount of time to complete the credentialing process. Therefore, the Department will so amend the regulation.</p>

Summary of Public Comment:	Agency Response:
<p>all such information requested by the MCHIP or, if information is not requested from the applicant, within 120 days of receipt of an application. The Department may impose administrative sanctions upon an MCHIP for failure to complete the credentialing process as provided herein if it finds that such failure occurs with such frequency as to indicate a general business practice."</p> <p>* The two associations jointly suggest language that would require fully-credentialed providers to remain credentialed if they change their place of employment and satisfy certain requirements be inserted. These providers would be required to practice within the same specialty, and provide to the new, non-MCHIP licensee employer within 60 calendar days of such change the effective date of the change, the new tax ID number and copy of W-9, as applicable, the name of the new practice, contact person, address, telephone and fax numbers and other material that may materially differ from the most recently completed credentialing application submitted by the provider to the MCHIP. This provision would not apply when the provider's prior place of employment or employer had been delegated credentialing responsibilities by the MCHIP</p>	<p>The Department understands the intent of the language is to reduce redundant credentialing requirements thereby reducing the administrative burden associated with credentialing without sacrificing quality. A provider that has been credentialed by one MCHIP licensee should not have to go through the same process if he changes his place or employment or employer.</p>

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<p>licensee. Nothing in the proposed section would be construed to require an MCHIP to contract or re-contract with a provider.</p>	
<p>There were two separate issues identified within one commenter's letter:</p> <ul style="list-style-type: none"> * Open panel PPO plans that lease networks should not have the responsibility of credentialing providers. Rather, the network should have to obtain state certification. * Open panel PPO plans should not have to comply with sections 12 VAC 5-408-220 - 240 concerning complaint and grievance mechanisms because these PPO plans do not restrict access to providers. 	<p>The Code of Virginia provides that each MCHIP licensee must have "reasonable and adequate procedures for credentialing and recredentialing the providers with whom it contracts." To adopt the intent of the suggestion would be to draft a regulation inconsistent with the Code.</p> <p>The Department concurs with the intent of the comment which is to ensure that the regulation has reasonable requirements for the different types of MCHIP licensees. This concurrence is demonstrated in the relevant section of the proposed regulation. Pursuant to 12 VAC 5-408-220-50, PPO plans need only comply with certain subsections of the complaint and grievance procedures. For example, unlike HMOs, PPOs in general need not have a quality assurance program for the purpose of improving covered person's health outcomes. The Department believes it has demonstrated considerable flexibility in this area and concludes that the proposed requirements are reasonable and that further erosion of quality standards may adversely affect Virginia residents.</p>
<p>Another commenter listed a number of concerns:</p> <ul style="list-style-type: none"> * The definition of "appeal" limits what can be appealed. * The definition of "complaint" no longer contains reconsiderations of a denial of coverage or payment nor adverse decisions. 	<p>The regulations now correctly differentiate between complaints and appeals. Many items formerly listed as an appeal are now correctly identified as a complaint. Decisions that can be appealed remain the same.</p> <p>The Department thought it best to define these words in a manner that is most meaningful to consumers. Therefore, it defined the terms as they are commonly used by MCHIP licensees in Virginia. The terms "complaint" and "adverse decision" are purposely mutually exclusive because these</p>

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<p>* The definition of "emergency services" strikes the prudent layperson standard, thus instituting a standard of reasonable expectation.</p> <p>* The discretion granted to the Commissioner to grant variances from the rules could open the door to a rash of requests for regulatory waivers by MCHIPs.</p> <p>* The proposed language exempts PPO compliance from 12 VAC 5-408-220(A)(1) yet the "A" is removed from the section as there is no longer a corresponding subsection "B".</p> <p>* The listed PPO exemptions from certain subsections of 12 VAC 5-408-240, 260, 270 and 280 eliminate crucial PPO quality assurance activities.</p> <p>* The standard for evaluating MCHIP licensees has been shifted from "making substantive progress in meeting it quality goals" to "using its best efforts to meet its QA goals."</p> <p>* The proposed regulation allows for conditional or provisional accreditation by a nationally recognized accrediting body.</p>	<p>terms have specific meanings.</p> <p>The Department believes it can achieve a level playing field for HMOs and PPOs by employing a standard that can be attained by all MCHIPs- the reasonable person standard. In addition, the Code of Virginia subjects HMOs, but not PPOs to the prudent layperson standard. The Department seeks to achieve consistency.</p> <p>The language concerning variances found in the regulation tracks language found in all regulations promulgated by the Department thereby promoting consistency. It allows for only necessary variances by the Commissioner and will not be abused.</p> <p>The Department regrets the oversight and intends to change 12 VAC 5-408-50 so that it no longer refers to a subsection "A".</p> <p>The Department understands that PPOs are not HMOs and has therefore decided to hold them responsible for only those activities which they typically have control.</p> <p>The Department believes it has proposed a reasonable standard. It has no interest in setting the standard so high that it penalizes MCHIP licensees that have used their best efforts, yet have not made substantive progress. For example, substantive progress may not be attainable for circumstances outside of the MCHIP licensee's control.</p> <p>The Department is satisfied with the standards of its accepted accrediting bodies yet it recognizes conditional or provisional accreditation may result from issues other than quality. Therefore, the Department is convinced that under certain circumstances, provisional or conditional accreditation is</p>

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<p>* Language that formerly required all MCHIP licensees to release detailed information from a national accrediting body is proposed to be changed so that the information must be given when requested.</p> <p>* The proposed language requests notification to the Department for "material" changes and not just any change.</p> <p>* An MCHIP licensee is no longer required to disclose credentialing information that it developed or information that is privileged by law.</p> <p>* Rather than require MCHIP licensees to provide covered persons with lists of all providers, they are allowed to notify covered persons that they can request a printed provider list or refer them to another means of accessing the provider list.</p> <p>* The proposed language does not require MCHIP licensees to maintain a medical record system nor does it reference HIPAA medical confidentiality regulation.</p>	<p>appropriate and not troublesome.</p> <p>The Department sought to ease the paperwork burden on the MCHIP licensees by eliminating the requirement to always send such detailed information, yet retaining the right to view relevant national accrediting body information when appropriate. The Department still has access to the information, yet every MCHIP licensee need not send unnecessary documents.</p> <p>The Department has decided there are benefits that may inure to Virginia consumers if MCHIP licensee administrative burdens are made reasonable. Likewise, the Department's administrative burdens in tracking this information are minimal when it requests only the information it needs. The Department has identified those changes in which it has an interest and has included them within the definition of "material."</p> <p>The Department seeks to maintain consistency with other statutes concerning privileged credentialing information. It likewise furthers the protection of an MCHIP's credentialing workproduct.</p> <p>Section 38.2 -3407.10 G of the Code of Virginia requires MCHIP licensees to provide to covered persons prior to enrollment and at least once a year a list of members in its provider panel. The reference to this section of the Code incorporates it by reference. Therefore, MCHIP licensees are indeed required to provide such lists to covered persons.</p> <p>The regulation recognizes that the majority of MCHIP licensees, PPOs, do not have medical records. Therefore, the regulation seeks to advance reasonable compliance expectations. The regulation does require the MCHIP licensees to comply with federal laws. It is overly burdensome for the Department to identify all federal laws to which the MCHIP licensees may become subject. For example, the HIPAA medical confidentiality regulation is not yet law and may be amended a number of times before it comes law. Therefore, the Department relies upon the broader language</p>

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<p>* Subsection B of 12 VAC 5-408-220 which describes the quality assurance program is deleted.</p> <p>* The language requiring MCHIP licensees to identify the resources necessary to successfully pursue improvement priorities and ensure that their quality assurance goals are effectively communicated is eliminated.</p> <p>* "A designated physician or clinical professional appropriate to the type of MCHIP" is substituted for a medical director.</p> <p>* Quality oversight and input by providers is minimized by changes including the deletion of the requirement that the quality assurance director report directly to the MCHIP's executive management.</p> <p>* Eliminates the need for the quality assurance plan to assess and respond to provider</p>	<p>found at 12 VAC 5-408-160 which states MCHIP licensees must comply with "applicable federal, state or local laws and regulations."</p> <p>The Department found the information formerly placed under this subsection to be either overly prescriptive and redundant. Because the goals of the quality assurance program are well defined in the former subsection A, the Department decided to delete subsection B.</p> <p>The Department believes the best evidence of an MCHIP licensee's having adequate resources to successfully pursue improvement priorities will be the development of a successful quality assurance program. Finally, the language concerning communication requirements was too prescriptive.</p> <p>Because some specialty MCHIP licensees such as dental plans do not have medical physicians, the Department decided to adopt language that was expansive enough to include the wide range of MCHIP licensees. The proposed language now requires the MCHIP licensee to designate a "board certified physician or clinical professional appropriate to the type of MCHIP." The Department believes this expansive language is broad enough to describe the different types of medical leadership.</p> <p>As previously mentioned, the Department was guided by a desire to make the regulation less prescriptive. The Department believes the extant regulation stifles creativity and that the intent of certain sections could be attained in other ways without sacrificing quality. The language at issue offers an example. The Department believes MCHIP licensees that can achieve compliance with the regulation with an indirect reporting relationship should be allowed to do so.</p> <p>The amended language is less prescriptive and echoes the goals of the quality assurance program. MCHIP licensees that have provider satisfaction information are free to respond to such</p>

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<p>satisfaction information.</p> <p>* Eliminates the requirement to examine identified overutilization and underutilization of services and to have interventions when either are identified.</p> <p>* Accessibility of services analysis can now be satisfied by contract language only.</p> <p>* Rather than require the MCHIP licensees to involve covered persons in determining care and treatment, they must now only provide basic health care services in a way that "does not impede" their involvement in care and treatment.</p> <p>* The requirement that MCHIP licensees assist covered persons in understanding the personal impact of a change or termination of benefits, services or providers is also deleted.</p>	<p>information if they choose. The Department understands MCHIPs with favorable results may not have anything to which to respond. Therefore, the language is now written broadly enough so that MCHIP licensees must set improvement goals gained from information which may include provider satisfaction data.</p> <p>The deletion of this language is desirable because some MCHIP licensees will not have access to this information. Also, its broad scope would necessitate continuous monitoring of every possible service with little benefit. Finally, the Department is not equipped to determine whether the applicant was correctly identifying the services as over or under utilized because these terms are not defined.</p> <p>An MCHIP may demonstrate it promotes accessible services in a number of ways, including contract language. The proposed language states, "Compliance can be demonstrated by evidence of contract language. . . ." The Department agrees that a better way to communicate that contract language is one way to demonstrate it promotes accessible services is to change the language to, "Compliance MAY be demonstrated by evidence of contract language. . . ."</p> <p>MCHIP licensees that have a small number of covered persons in their plans may find mandatory covered person involvement in care and treatment decisions burdensome. The licensees have no authority to force covered persons to participate in their care should they choose to decline the offer to participate. The amended language represents a more reasonable approach while supporting voluntary covered person involvement in the treatment process.</p> <p>The extant regulatory language is too broad. The phrase requiring the MCHIP licensee to assist every covered person "affected by a change" can involve a large number of circumstances. Because there are other sections of the regulation concerning the education of covered persons, such as 12 VAC 5-408-190, the Department felt the deletion of such broad language was appropriate.</p>

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<p>* The extant language states that when an MCHIP licensee does not have a health care provider with the appropriate training and experience capable of meeting the health care needs of a particular covered person within its network, the MCHIP licensee shall ensure that the covered person is referred to a health care provider outside of the network. The amended language requires the MCHIP licensee to "allow" the covered person to be referred, as opposed to mandating that the MCHIP licensee "ensure" that covered person is referred.</p>	<p>Because the Department believes it is impossible for MCHIP licensees to "ensure" that a covered person is referred in such circumstances, the Department has amended the language so that MCHIP licensees must allow for such referrals. Health practitioners make such referrals and not the MCHIP licensees. Therefore, the Department has suggested language that reflects what it can reasonably expect of an MCHIP licensee.</p>
<p>* Travel time specifications for hospital-based services are eliminated. Rather, the new provision states that an MCHIP licensee must set reasonable and adequate standards for the number and geographic distribution of institutional service sites.</p>	<p>The Department believes that assigning a travel time specification in a state characterized by great geographic variation is likely to create compliance difficulties. Amending the language to establish one that is "reasonable" assures language that is broad enough to encompass the many variations in travel time.</p>
<p>* Rather than requiring the MCHIP licensee to have a 24-hour medical care access system in place, the regulation now provides that the MCHIP licensee must require that participating providers allow covered persons access to medical care or phone access to a physician or qualified health care professional who can refer covered persons to prompt urgent and emergent medical care.</p>	<p>The Department recognizes that MCHIP licensees cannot provide access to medical care in places where medical care does not exist. In addition, it is the participating provider and not the MCHIP licensee who makes medical decisions regarding appropriate urgent and emergent medical care. The amended language provides notice to the regulated community that the Department expects it to require participating providers to allow its covered persons access to medical care in such circumstances.</p>
<p>* The amended language</p>	<p>Rather than stipulate that MCHIP licensees must comply with</p>

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<p>deletes the requirement that MCHIP licensees comply with the federal Emergency Medical Treatment and Active Labor Act.</p> <ul style="list-style-type: none"> * The provision references clinical service evaluation, which is inconsistent with the prior section's reference to clinical performance evaluation. * The amended regulation eliminates the requirement that the collected data allow for intra- and intersystem comparisons for the purpose of improving patient health outcomes and clinical health delivery systems. * This section eliminates the requirement that the MCHIP licensee inform covered persons and providers which services are delegated and how they are assessed. * The amended language eliminates the MCHIP licensee's duty to evaluate the delegated health entity's quality improvement program at least annually and to report its evaluation to the delegated health entity. * MCHIP licensees must utilize the applicable utilization review and management standards of the nationally recognized accrediting bodies as appropriate to the type of MCHIP licensee and 	<p>a particular federal law that arguably is not applicable to managed care entities, the Department decided to require MCHIP licensees to comply with all "applicable" state and federal laws as stated in 12 VAC 5-408-160B.</p> <p>The Department believes the language is consistent because the rendering of clinical services is a part of clinical performance. In addition, there is no language that was amended that resulted in this alleged inconsistency. The extant regulation also contains references to clinical services as a part of clinical performance.</p> <p>Less administratively sophisticated MCHIP licensees may have difficulty meeting the extant language. Also, the remaining subsections adequately describe the data the Department hopes MCHIP licensees will utilize for clinical service evaluation. Therefore, the Department believes the deletion of this language is appropriate.</p> <p>Rather than require the MCHIP licensees to provide information to covered persons that might be potentially confusing, the Department decided to delete it because there are sections of the regulation such as 12 VAC 5-408-190 that allow for educational information concerning the procedures for obtaining care.</p> <p>The remaining subsections of the regulation allow for integration of the monitoring of delegated service entities into the MCHIP licensee's quality assurance program as well as actions to be taken when its expectations have not been met. The Department believes the annual evaluation may therefore be superfluous.</p> <p>The Department does not understand the concern the commenter has with the amended language as the commenter merely described the change.</p>

Summary of Public Comment:	Agency Response:
<p>acceptable to the Department unless more stringent standards are applicable under law.</p>	
<p>* A nationally recognized accrediting body commented that subsection 360 be amended so that it does not limit the accrediting body's accreditation or certification to any particular program.</p>	<p>The Department recognizes the misplaced phrase concerning utilization review and management might lead the reasonable person to conclude the Department was making such a limitation. Therefore, it has decided to accept the suggested language.</p>
<p>An MCHIP licensee suggests the following:</p> <p>* The certificate of quality assurance should be effective for three years or the onsite reviews occur every two or four years. Such a change would allow for better coordination in the renewal process.</p> <p>* The requirement that a PPO plan that leases a network notify all participating providers of material changes affecting the MCHIP plan is overly burdensome.</p> <p>* Compliance with the language requiring covered person information to be in the language of the major population groups served is difficult because the term "major population group" is not defined.</p> <p>* Subsection 230 C 3 requires the quality assurance program</p>	<p>Even if the Department believed the suggestion was a reasonable one with merit, the timeframes at issue are defined by statute. Such a change would result in a regulation that exceeds its statutory authority.</p> <p>The Department believes that because it has carefully crafted language that defines a material change such a requirement will not be burdensome.</p> <p>The Department would prefer to have the language remain intact so that MCHIP licensees could define it as appropriate. In the alternative, the Department suggests MCHIP licensees might want to adopt the equally flexible federal guidelines which suggest the types of language assistance that must be in place to ensure meaningful access depend on a variety of factors, including the size of the facility or covered entity, the size of the eligible limited English proficiency population it serves, the resources available to the facility and the frequency with which persons with limited English proficiency come into contact with it.</p> <p>The intent of drafting such broad language is to make the requirement flexible enough to encompass the many different</p>

Summary of Public Comment:	Agency Response:
<p>to be structured to include a designated physician or clinical professional appropriate to the type of MCHIP licensee. The commenter believes this language to be too vague and wonders whether nurse practitioners or nurses qualify.</p> <p>* Section 260 E regards the notification to affected insureds of terminated providers. However, no definition of affected insured is present and no explanation of acceptable notification is present. MCHIP plans that do not use a gatekeeper should not be required to comply.</p>	<p>types of managed care plans. For example, dental HMOs would not likely employ a physician. The Department has therefore deleted the reference to physicians. The professional appropriate to the type of dental MCHIP would be a dentist.</p> <p>Any insured likely to have a medical need to know of the terminated provider is an affected insured. The Department will accept all reasonable notification. Because PPOs typically do not have a gatekeeper, subsection 50 exempts them from compliance.</p>
<p>A national accrediting organization sent a request to be recognized by the Department as a "nationally recognized accrediting body."</p>	<p>The Department reviewed the materials sent by the national accrediting organization and was concerned that it lacked information regarding, among other things, how it would determine whether the MCHIP licensee had an appropriate complaint or appeal system. Because this is an important consumer protection mechanism, the Department has decided to reject the request.</p>

Detail of Changes

Please detail any changes, other than strictly editorial changes, that are being proposed. Please detail new substantive provisions, all substantive changes to existing sections, or both where appropriate. This statement should provide a section-by-section description - or crosswalk - of changes implemented by the proposed regulatory action. Include citations to the specific sections of an existing regulation being amended and explain the consequences of the changes.

The Department proposes three changes to the amended regulation in response to the comments received. Items 6 and 7 will be placed after 12 VAC 5-408-170D.5. The intent of these changes is to ensure that MCHIP licensees credential providers in a timely manner. It also affords an administrative mechanism to allow for the continued credentialed status for providers who change their place of employment but who continue to practice in the same specialty. The language of items 6 and 7 will read as follows:

- 6. A requirement that the MCHIP licensee notify the applicant within 60 calendar days of receipt of an application if information is missing or if there are other deficiencies in the

application. The MCHIP licensee shall complete the credentialing process within 90 calendar days of the receipt of all such information requested by the MCHIP licensee or, if information is not requested from the applicant, within 120 calendar days of receipt of an application. The Department may impose administrative sanctions upon an MCHIP licensee for failure to complete the credentialing process as provided herein if finds that such failure occurs with such frequency as to indicate a general business practice.

7. A provider fully credentialed by an MCHIP licensee, who changes his place of employment or his non-MCHIP licensee employer, shall, if within 60 calendar days of such change and if practicing within the same specialty, continue to be credentialed by that MCHIP licensee upon receipt by the MCHIP licensee of the following:

- a. The effective date of the change;
- b. The new tax ID number and copy of W-9, as applicable;
- c. The name of the new practice, contact person, address, telephone number and fax number; and
- d. Other such information as may materially differ from the most recently completed credentialing application submitted by the provider to the MCHIP licensee.

This provision shall not apply if the provider's prior place of employment or employer had been delegated credentialing responsibility by the MCHIP licensee.

8. Nothing in this section shall be construed to require an MCHIP licensee to contract or re-contract with a provider.

The final change will clarify the language found at 12 VAC 5-408-360 C. As written, a phrase implies one nationally recognized accrediting body is limited to a particular accreditation or certification program. The proposed language is consistent with the intent of the language which is intended to mean that any relevant accreditation or certification program with comparable utilization review standards by any nationally recognized accrediting body is acceptable to the Department. Subsection C will now read:

The MCHIP licensee, or its contracted private review agent, or other delegated service entity for utilization review and management services, may demonstrate compliance with the utilization management and review requirements of this section by attaining accreditation or certification with the American Accreditation HealthCare Commission/URAC, the National Committee for Quality Assurance, or other nationally recognized accrediting body with comparable standards for utilization review or management accepted by the Department.

Family Impact Statement

Please provide an analysis of the regulatory action that assesses the impact on the institution of the family and family stability including the extent to which the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

The intended action should not have any direct effect on the institution of the family and its stability. The proposed amendments do not erode the authority and rights of parents in the education, nurturing, and supervision of their children; encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, one's children and/or parents; they do not strengthen or erode the marital commitment nor do they increase or decrease a family's disposable income.